INDIVIDUAL ENROLLMENT FORM
INSTRUCTIONS

PROVIDER NAME (field 1) – Enter your individual provider name exactly as it is entered on the attached W-9 form. **This is the name you will use to bill the program.**

BUSINESS NAME (field 2) – Enter the name you will be doing business as, if different from above.

BUSINESS TYPE (field 3) – Enter your type of business.

OWNER/ADMINISTRATOR, MANAGING EMPLOYEE or OFFICER OF CORPORATION NAME – (field 4) – Enter the name of the owner/administrator, manager or chief operating officer of your business or facility.

SOCIAL SECURITY NUMBER (SSN) *or* FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) – (field 5) – Enter your individual Social Security Number (9 - digits) *or* your individual or group FEIN (9 - digits).

> **NOTE: Enter either the SSN or FEIN.** Individual providers must enter the same name/SSN or name/FEIN combination as was entered on the original W-9 form.

SERVICE LOCATION ADDRESS – (field 6) – Enter the complete physical address of the location where the business or where the actual services are conducted. **P.O. Box alone is not acceptable as a service location.**

PAY TO ADDRESS – (field 7) – Enter the complete address of the location where financial correspondences should be forwarded. Examples: Remittance Advice/RA, Explanation of Benefits/ EOB.

MAIL TO ADDRESS – (field 8) – Enter the complete address of the location where correspondences should be forwarded. Examples: Direct Mailings regarding billing, policy related changes, etc.

TELEPHONE – (field 8) – Enter the area code and telephone number of the location where direct mailings are mailed.

BILLING SERVICE ADDRESS – (field 9) – Enter the complete address of the location where the billing information is prepared.

BILLING TELEPHONE – (field 9) – Enter the area code and telephone number of the location where the billing information is prepared for billing inquiries. Also, provide a Mobil number, if applicable.

ADDITIONAL PRACTICE LOCATIONS ADDRESS – (field 10) – Enter the complete physical address of additional location(s) where the business or where the actual services are conducted. If more than 3 locations please provide information on a separate sheet of paper and include with this application.

OFFICE EMAIL ADDRESS – (field 11) – List the office email address for the actual provider (doctor) to receive future correspondences via email.

CONTACT PERSON – (field 11) – Please indicate who the main contact person is for correspondences.

MEDICAL LICENSE, LICENSE CHEMICAL DEPENDENCY *or* CERTIFICATION NUMBER – (field 12) – If you are required to be licensed to provide services, enter your medical license, chemical dependency license or certification number. **A copy of the current valid medical license, chemical dependency license or certification letter must be submitted with the application.** *At the time of renewal,*

a copy of the renewed medical license, chemical dependency license or certification letter must be sent so that the provider can continue as an active provider in the Medical Assistance Program.

CURRENT ENROLLMENT WITH MEDICAL ASSISTANCE – (field 13) – If you have been enrolled previously with RI Medical Assistance as an individual or within an established group, please provide your Medical Assistance ID number/s.

MERGER/BUY OUT – (field 14) – Is this enrollment due to a purchase of an established practice?

OUTSTANDING BALANCE – (field 15) – List any outstanding balance owed to RI Medical Assistance from a previous enrollment.

MEDICAL SPECIALTY – (field 16) – Enter the appropriate Specialty; e.g., MD - Internist; DDS - Oral Surgeon. (Disregard if you provided your NPI & Taxonomy/ies).

NATIONAL PROVIDER IDENTIFIER – (field 17) – Enter the CMS (Centers for Medicare/Medicaid) established NPI number. (Medicare is stating that providers who are incorporated need to be enrolled as a group with their group (type 2) NPI. Please complete the group application if this applies.) Also include your authorization letter from the Enumerator/contractor NPPES. If your agency has been exempt from receiving an NPI, please attach a copy of a letter stating such.

TAXONOMY(ies) – (field 18) – Enter the Taxonomies established by CMS.

MEDICARE NUMBER – (field 19) – Enter your Medicare number provided by Medicare. (DME providers only)

CLIA NUMBER – (field 20) – For clinical labs and hospitals, enter the Clinical Laboratory Improvement Act (CLIA) number found on the CLIA Certificate of Compliance issued by HCFA. Include the documentation showing the specialties for which you are certified to bill.

NUMBER OF LICENSED AND SWING BEDS – (field 21) – If applicable, enter the number of licensed and swing beds in your facility.

EMC BILLER – (field 22) – If you intend to bill via electronic media, please fill out the EMC interest form/Trading Partner Agreement. http://www.dhs.ri.gov/dhs/heacre/provsvcs/prvforms/tpa.pdf.

FISCAL YEAR END – (field 23) – Enter the month in which your fiscal year ends.

HOSPITAL/INSTITUTION EMPOYEE – (field 24) – Are you working part time for full time.

NAME OF FACILITY – (field 24) – Provide the name of the hospital or institution.

ENROLLMENT EFFECTIVE DATE or DATE FIRST SERVED RIMA client – (field 25) – If a Medical Assistance client is currently under your care, please provide the date in which you began services. **or** Provide a date in which you are interested in establishing your practice as a Medical Assistance Provider.

EXCLUSIONS UNDER THE CODE OF FEDERAL REGULATIONS – (field 26) – If YES, provide information relating to any exclusions under Chapter 42, Public Health, Department of Health and Human Services.

DOCUMENT DEBARMENT, SUSPENSION, EXCLUSION, CRIMINAL OFFENCE FROM FEDERAL PROGRAM – (field 27) – Provide any information/documentation pertaining to any debarment, suspension, exclusion, or criminal offence from a federal program.

Hospitals must include a Rates and Revenue Codes form with the application.

PROVIDER SIGNATURE AND DATE – Application must be signed by the Individual Applicant.
Stamped or photocopied signatures are not acceptable.

MAIL TO:

EDS / Provider Enrollment Unit
P.O. Box 2010
Warwick, RI 02887-2010

Requests for updates to your provider file, such as name or address changes, must be signed by the provider or authorized administrator and sent to the address above.

An incomplete application will be returned for completion.
Avoid this delay by submitting a complete application.